International Journal of Business Quantitative Economics and Applied Management Research
ISSN: 2349-5677
Volume 2, Issue 2, July 2015

Mitigating India's Healthcare woes –Delivering Universal Health through Insurance

Dr. Abhijeet K. Chattoraj
Associate Professor, Amity Business School,
Amity University, Mumbai

Abstract

The paper tries to throw light on healthcare scenario in India vis-à-vis Universal Health. The paper discusses various models to better serve the healthcare needs of India's vast population .The paper also throws light on how some of the countries are fulfilling the healthcare needs of their people. The paper makes a strong pitch for health insurance companies to deliver universal health by adopting a proper model and working in tandem with the various state governments.

I. Introduction

All over the world, one topic which is most discussed, debated, contended, used and also abused is Universal Health Coverage simply because of the fact that it is one of the major arbiters of success of a political party. Universal Health coverage has been defined by WHO "as ensuring that all people have access to needed health services – prevention, promotion, treatment and rehabilitation-without facing financial ruin because of the need to pay for them .It is very disturbing to find even today that people in many countries plunging to financial ruin or debt trap owing to catastrophic costs of health care. It is estimated that globally 150 million people suffer financial catastrophe every year. On an average 100 million people are pushed to below poverty lines every year. The prevailing scenario is no better in India. The government approach to mitigate health care needs is somewhat lukewarm despite the fact that Government of India is also one of the signatory nations of millennium development goal.

Ensuring universal health has a long standing implication in view of fast changing political and socio-economic scenario. In fact the need to have universal health was recognized way back in September 1978 at Alma-Ata the Declaration. It was felt, here,' Health for All' can possibly be realized by delivering and addressing primary health care .

International Journal of Business Quantitative Economics and Applied Management Research
ISSN: 2349-5677
Volume 2, Issue 2, July 2015

Most countries have moved ahead with developing a health –financing system which can take them closer to universal health coverage. The models adopted to achieve universal health coverage is different in different countries but all countries try one thing religiously i.e. to ensure that people in their countries can access health care services without facing much financial hardship. The world Health report 2010–'Health system Financing –The Path to Universal coverage' suggested the member states about the different ways to get closer to Universal coverage and also explains most importantly how to sustain the gains financially. The raising of resources internally to finance a health care needs and the accompanying system as one of the options- the report suggested. The other important option suggested is to strive for less reliance on out of Pocket spending by developing adequate pooling mechanism.

This brings to the forefront the importance of health insurance as it can play a significant role in mitigating health care problems by pooling the risk. Insurance is a mechanism for financing health risks by combining sufficient loss exposure units to make the loss predictable. It is a mechanism of spreading cost of treating a health event over a group of individuals or households.

Most advanced countries try to address healthcare needs of its people by striking balance between universal health and Private voluntary insurance. In fact Private voluntary insurance (PVI) or Private Medical Insurance (PMI) coexists even in countries which have strong government mechanism to provide healthcare services. Even in U.K. where NHS (National Health Services) provide universal health services for all based on clinical need and not ability to pay - source – (NHS Plan 2000) , Private healthcare services and private medical insurance have flourished over the period of time. In fact private healthcare services supplement NHS. The private Medical insurance today provides the financial cushioning to those who get healthcare services in independent hospitals.

Healthcare scenario in India -India's healthcare suffers heavily on account of inadequate resources. This has resulted in poor healthcare infrastructure, health service coverage and above all health status outcomes. India's health expenditure on health is merely 3.8% of GDP (2012 as against 3.9% in 2011); the global benchmark is 8.6%; Private expenditure on health is 69.5 % of total expenditure on health – global benchmark is 42.3%. The general government expenditure on health is 30.5 % of total expenditure on health – global benchmark is –57.6 %. The General government expenditure on health is 4.3 % of total government expenditure as against global benchmark 14.1%.This has fallen sharply from 8.2% in 2011(Source- World Health Statistics 2014 and 2015 by WHO)

The Out-of-pocket expenditure has gone up to 87.2% in 2012 (as against 86.3 % in 2011)out of total private expenditure on health as against global benchmark 52.6%;. Private prepaid plans is

International Journal of Business Quantitative Economics and Applied Management Research
ISSN: 2349-5677
Volume 2, Issue 2, July 2015

3.3%(4.6 % in 2011) of private expenditure on health –(global benchmark is 36.2%). Per capita total expenditure on health is 196 (PPP int. $) in 2012 (146(PPP int. $)in 2011)against global benchmark of 1173; Per capita government expenditure on health is 60(PPP int. $) in 2012 up from 44 in 2011 (PPP int. $)- global benchmark is 676(619 in 2011)

If we look at the hospital bed density, it is merely 7 beds per 10,000 persons as against the global benchmark of 27;India has just 7 doctors per 10,000 persons as against global requirement of 13.9 doctors. We have just about 17.1 Nursing and midwifery personnel as against global benchmark of 28.6.

The scenario of health service coverage is no better. The antenatal coverage is measured in terms of one and four visits .They are merely 75% and 72% respectively between 2007-14 as against global benchmark of 83% and 64% respectively. Only 67% births are attended by skilled health personnel.

Birth attended by safer caesarean section is just 8% between 2007and 2014 – the global benchmark for the former is 74% and 17% for the latter. Similarly the immunization coverage among one year olds for Measles and DTP3 in 2013 is 74% and 72% as against global benchmark of 84% and 84i% respectively.

India's HDI (Human Development Index) rating is 135 out of 185 countries as per the latest Human Development Report -2014 by UNDP. India's composite Human Development Index (HDI) is merely 0.586. It may be noted here that this composite index is arrived at by taking into consideration three important parameters constituting human development— the level of health, education and income.

The level of health is factored in terms of Life expectancy at birth i.e. the number of years a new born infant is expected to live- presuming the prevailing patterns of age-specific mortality rates at the time of birth remains the same throughout the infant's life. Life expectancy at birth in 2013 is 66 which is lower than the median value of 74 years and South East Asia Region 68 and the global benchmark of 71 years

The scenario in terms of health outcomes though improving but not likely to catch up the millennium Development goals set for the year2015.The Maternal mortality rate has reduced by more than 50%, and has come down to 190 deaths per 100,000live births in the year 2013 as compared to 370 deaths in 2000.

The neonatal mortality rate -the probability of death occurring during the first 28 days of life was 31 per 1000 live births in 2012 and 29.2 in 2013. The global neonatal benchmark in 2013 was

International Journal of Business Quantitative Economics and Applied Management Research
ISSN: 2349-5677
Volume 2, Issue 2, July 2015

20.0.The Infant mortality rate – the probability of dying by the age 1 per 1000 live births got reduced by almost 50% over the period 1990–2013, and was41.4 deaths per 1,000 live births. Similarly the under-5 child mortality rate- the probability of dying by the age 5 per 1000 live births was 52.7 in 2013 as against 125.9 in 1990. The global benchmarks for IMR 1 year and IMR 5 year are 33.6 and 45.6 respectively.

II. Financing

The financing of universal health care is the most difficult and prickly decision as most countries struggle to devise mechanism to raise funds for financing their healthcare costs. The important consideration depends greatly on the composition of universal healthcare services. The boundary of care needs to be defined very well. Most countries provide ambulatory care free of cost and cap the tertiary care. On the other hand, most countries want to cover only the diseases of catastrophic nature in their universal health care. Some combine both the ambulatory care and catastrophic diseases. Many countries are coming with innovative ideas to finance their healthcare costs. Some of the examples are railway or air ticket levies, issuing bonds, currency transaction levy.

According to The World Health Report -Health systems Financing- The path to universal coverage by WHO (2010) India can leverage its strong foreign exchange market, with daily turnover of US$ 34 billion to generate US$ 370 million per year. It just has to impose acurrency transaction levy of 0.005% on this volume of trade to generate the above amount.Another study by Shankar Prinja, PankajBahuguna, Andrew D. Pinto, Atul Sharma, GursimerBharaj, Vishal Kumar, Jaya Prasad Tripathy, ManmeetKaur and Rajesh Kumar found that the cost of delivering universal health care delivery through the existing mix of public and private health institutions would be INR 1713 (USD 38, 95%CI USD 18–73) per person per annum in India. This cost would be 24% higher, if branded drugs are used. The study further added that extrapolation of these costs to entire country would imply that the Indian government needs to spend 3.8% (2.1%–6.8%) of its GDP.

Purchasing is another prickly issue in implementing universal healthcare. The government allocating funds to finance its own service providers through government revenues or some time going through the insurance route to finance the same is a prominent purchasing mechanism. The other is separate institutional arrangement of raising funds (mostly insurance funds) through which purchases are made for healthcare services from service providers on behalf of the population. The most prevalent way is where the individuals are fending for their own medical

International Journal of Business Quantitative Economics and Applied Management Research
ISSN: 2349-5677
Volume 2, Issue 2, July 2015

expenses. The first two are institutional arrangements of making purchase for healthcare services.

In India, we follow the first option wherein, government allocates funds to finance its own health care services .The total budgetary allocations made by Government of India under health sector in 12th Plan (2012-17) are Rs. 300018.00 crores. The allocation on Health is Rs.75, 145.29 crores; on AYUSH Rs.10,044 .00crores ; on NHRM (National Rural Health Mission) it is 1,93,405.71 crores; NHM/NACO , it is 11,394.00 crore and on health research ,it is Rs. 10029.00 crore . The budgetary allocations over the period have gone up but the total expenditure vis-à-vis GDP has gone down.

III. Channelizing the Monthly Per Capita Expenditure on Health to Insurance Route

The NSS 66th Round (Report no -541(66.1.0/3) on "Household Consumption of Various Goods and Services in India "observed that the monthly per capita expenditure of a rural Indian on institutional (expenditure incurred as inpatient)and non- institutional medical expenses was Rs.17.42 and Rs. 39.49respectively. Similarly the monthly per capita expenditure of anurban Indian on institutional and non- institutional medical expenses was Rs.36.37 and Rs. 62.69 respectively. Thus a rural India spends about Rs.56.91 per month and Rs.682.92 per year towards medical expenses. Similarly an urban Indian spends about Rs.99.06 per month and Rs.1188.72 per year towards medical expenses. In the given scenario, a reasonable part of the expenditure can be routed through insurance to provide accessible and equitable healthcare. The moot point here is how to pool this fund.

In any case most of the state governments are running various health schemes to provide health care to the marginalized section of the society i.e. the BPL (below poverty line population). The pooling discussed as above needs to be arranged for those who have some paying capacity and are above the poverty line). The insurance companies should look for different models to tap this potential market.

Various Models to address the health care needs – There are several important models through which the health care needs of people are met or addressed. The model chosen depends on the financing modality a country wants to adopt and the value it is wedded with. In the UK system, significant portion of the health care needs are addressed through revenue raised through taxation. U.K. follows Beveridge Model which is a single payer system i.e. the healthcare is primarily financed by Government through tax. In USA , private insurance markets finances more than a third , while the state pays the rest. In Maldives, the bulk of healthcare needs are

International Journal of Business Quantitative Economics and Applied Management Research
ISSN: 2349-5677
Volume 2, Issue 2, July 2015

borne by state through the insurance route. In Myanmar, the healthcare need is directly paid by the patients. In Germany and Belgium – the healthcare needsare met by health insurance.

Germany follows Bismarck model which is also known as multi payer system. It follows the SHI or Social Health insurance scheme as their health insurance is based on the value of Solidarity. People appreciate the value of cohesion and together want to share everything.SHI schemes are statutory programmes. The premium charged is based on income –meaning, thereby, those with higher income pay more and vice versa. The simple rule that follows in this system is that people would fulfill healthcare needs as per their clinical needs and pay according to their ability. Around 92% of the population is covered by state health scheme or GVK (Gesetzlichekrankenkasse). SHI model works in Germany because it has huge population working in the formal sector.

Taiwan implemented universal health insurance through National Health Insurance in 1995 - providing equal access to health care for all citizens and controlling total health spending to a reasonable level. The NHI provided a comprehensive benefit package that covers preventive and medical services, prescription drugs, dental services, Chinese medicine, and home nurse visits. The NHI incorporates a $5copayment for each outpatient visit to clinics, an $8 copayment for each visit to hospital outpatient clinics, and 10 percent coinsurance for inpatient services but capped the total amount that a patient has to pay each year at 10 percent of the average national income per person.

It becomes difficult for a country to address the healthcare needs of a huge population engaged in informal sector. The best way to reach such population is through CHI (Community Health Insurance) model. The model follows twin value of solidarity and risk sharing. The risk sharing takes place both between high and low risk or healthy and sick.

The premium is community rated which means the premium charged reflects the average cost of illness. Both high and low risk pay the same average price .Thus it also follows the third value i.e. equity. Risk-pooling is the most characteristic of these systems as health services are provided according to people's need rather than their ability pay for health services .Bangladesh has emerged with successful CHI models like Gonosasthya Kendra (GK) by differentiating contributions according to four social groups. Self-Employed Women's Association(SEWA)and ACCORD are two leading examples of CHI models in India.

The third model PVI or PHI has found space in almost every country primarily because the other systems fell short of expectations of the people. The model follows risk based pricing which

International Journal of Business Quantitative Economics and Applied Management Research
ISSN: 2349-5677
Volume 2, Issue 2, July 2015

means the price charged is based on the amount of risk one transfers to the pool. The higher the risk transferred, the higher would be the premium.

The model doesn't follow the traditional pooling which believe that the lower risk would subsidize the higher risk. The model is somewhat is equitable in the sense low risk people don't have to pay for the high risk.

The fourth model GIHI or Government initiated health insurance which is primarily run by governments with the help of some trusts. They often take the insurance route (at least in India) . They are primarily targeted to BPL or at time APL (above poverty line) population which cannot pay for insurance.

Each model is fraught with some problems. SHI model suffers from moral hazard .Although one should use health services strictly based on clinical needs, most often people tend to overuse services as they don't have to pay. In the absence of clinical guidelines in place, the providers tend to charge more than what it should be. PVI or PHI model suffers from anti selection. People whose healthcare needs are more tend to join the scheme often at lower price. As a result, the premium goes up every year. CHI works when the group unity is very strong. GIHI model calls for strong political will and extremely efficient management for its survival and sustainability.

IV. Health Insurance – the Indian Scenario

India has gone for all the four models stated above to address the healthcare needs of its population. However, India's total healthcare expenditure in 2012 is only 3.8% of its GDP (Gross Domestic Product) which is quite low when we compare the same with some of the developed countries like Australia (8.9%) Japan (10.3%) China (5.4%) UK (9.3%) USA (17.0%). Even Maldives with 11.4% fares far better than India. What is even more worrying is the General Government Expenditure on health….? It is only 30.5% of the total health care expenditure. The general government expenditure on health is merely 4.3% of the total government expenditure in 2012.

The above facts are pointers to one thing i.e. the concern of the governments of these countries towards their marginalized population. However, the most worrying fact is the share of private expenditure on health vis-à-vis total expenditure on health. It is alarmingly high in India.

It is 69.5% India's share of out of pocket expenditure to the total private expenditure on health is one of the highest in the world. It is 87.2% .Private prepaid plan i.e. Private prepaid plan i.e. Insurance constitutes merely 3.3 % of the total private expenditure on health. If we compare the same with The USA, out of pocket expenditure constitutes only 22.4% of total private

International Journal of Business Quantitative Economics and Applied Management Research
ISSN: 2349-5677
Volume 2, Issue 2, July 2015

expenditure on health and private prepaid plans constitute 63.7% of the private expenditure on health.

The contrasting figures clearly state one thing that India is almost a virgin field for prepaid plans. This is both an opportunity and a challenge for private health insurance. A sizeable portion of India's population is looking for financial cushioning to mitigate their financial hardships in the event of an illness. Low social security expenditure shows government's apathy towards health care needs of its people.

The global experience indicates that social health insurance schemes play important role in achieving extensive and inclusive health insurance coverage. In most developed countries, a combination of Social Health insurance, private voluntary insurance, state run health insurance schemes and Community Health insurance schemes work in tandem to meet the healthcare needs of its population.

India is no exception to this experiment. India's tryst with health insurance began way back in 1950 with the introduction of Employee State Insurance Scheme or ESIS as it is popularly known as today. It was followed by the launch of Central Government Health Scheme (CGHS) in 1954- both government initiated schemes but followed the SHI model where employees contribute a certain percent of their wages. The employers also contribute in a specified manner.

Some of the Important landmarks in Health Insurance /Schemes- in chronological order :-
1.Employees's State Insurance Scheme (ESIS); 1952- a SHI model,

2. Central Government Health Scheme (CGHS); 1954 - a SHI model ,

3. "Mediclaim" by four PSU companies in 1986.

4. Opening up of health insurance market in 1999 onward.

5. Yeshasvini Co-operative Farmers Health Care Scheme in Karnataka; in 2003.

6. Launching of National Rural Health Mission (NRHM) in 2005.

7. Rajiv Aarogyasri Health Insurance Scheme in Andhara Pradesh; in 2007

8. RashtriyaSwasthyaBimaYojna(RSBY), a centrally sponsored scheme being implemented in 24 states in India in 2008 – a GHI MODEL

International Journal of Business Quantitative Economics and Applied Management Research
ISSN: 2349-5677
Volume 2, Issue 2, July 2015

9. Critical Life-Saving Health Insurance Scheme (RSBY Plus) in Himanchal Pradesh; in 2010. 10. Vajpayee Aaroyasri Scheme in Karnataka; in 2010 – A GHI Model

11. Chief Ministers Comprehensive Health Insurance Scheme, Tamil Nadu in 2012-A GHI Model

12. Rajiv Gandhi JeevandayeeArogyaYojana (RGJAY) (Maharashtra); in 2012-A GHI Model

During 2013-14 total no. of persons covered by health insurance companies was 21,62,31,000 and the premium collected was 1749454.02 lacs. The various government sponsored schemes reached through insurance covered 3,20,87,000 persons . The above figures indicate how health insurance has been penetrating the psyche of people in India over a period of time..

V. Delivery Mechanism

Universal healthcare is not possible unless proper delivery mechanism is developed. Accessing healthcare is the biggest problem. Most rural people don't access healthcare just because the fact that they have to travel long to access healthcare services. The rural India needs healthcare the most. The PPP model is the best way to build up networking with hospitals and doctors. Insurance companies can also partner with NRHM (National Rural Health Mission) to leverage the reach of the latter to deliver healthcare services. Similarly private players should be invited to build healthcare infrastructure for the needy people as per their healthcare needs. The emergence of super specialty hospitals in large numbers don't really capture the healthcare needs of the major chunk of Indian population

VI. Conclusion

There is great opportunity for health insurance companies in India to work in tandem with various state governments to design universal health cover. They can partner with state governments and leverage their existing healthcare facilities and also gradually build strong network over a period of time to fulfill the healthcare needs of a vast population. Some state governments have really done well with their health schemes and the results are palpable for everybody to appreciate.

International Journal of Business Quantitative Economics and Applied Management Research
ISSN: 2349-5677
Volume 2, Issue 2, July 2015

Refernce

1. Central Bureau of Health Intelligence- Govt. Of India (http://cbhidghs.nic.in/index1.asp?linkid=305-)
2. The Cost of Universal Health Care in India: A Model Based Estimate-Shankar Prinja1, Pankaj Bahuguna1, Andrew D. Pinto2,3, Atul Sharma1, Gursimer Bharaj1, Vishal Kumar1,
    a. Jaya Prasad Tripathy1, Manmeet Kaur1, Rajesh Kumar1*
3. Does Universal Health Insurance Make Health Care Unaffordable? Lessons From Taiwan- by Jui-Fen Rachel Lu and William C. Hsiao0
4. NSS Report No.541: Household Consumption of Various Goods and Services in India
5. World Health Statistics 2014 AND 2015 by World Health Organization
6. (http://www.who.int/gho/publications/world_health_statistics/2014/en/)
7. Insurance Regulatory and Development Authority (Health Insurance) Regulations, 2013
8. http://apps.who.int/iris/bitstream/10665/170250/1/9789240694439_eng.pdf?ua=1&ua=1
9. Community based Health Insurance Schemes in Developing Countries: facts, problems and perspectives (http://www.who.int/health_financing/en/community_based_health_dp_e_03_1.pdf)